

## Morita Therapy for Schizophrenia

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### Background

As well as drug treatment, management of schizophrenia should also focus on wider social aspects of living in the community. There are many kinds of intervention strategies available involving both the patient and the wider family unit; Morita therapy is one of these. It is a systematic psychotherapy based on Eastern psychology, named in 1919 after Shoma Morita, a Japanese psychiatrist. Morita therapy involves a behavioral, structured program and tries to lead patients from preoccupation with somatic symptoms and attempts to eliminate neurotic symptoms through 4 phases by accepting it as natural, while engaging an outward perspective on life and increased social functioning.<sup>1</sup> It is in wide use in China<sup>2</sup> and also in Japan and a few Western countries.<sup>3,4</sup> Full details of this work are published on the Cochrane Library.<sup>5</sup>

### Objective

To evaluate the clinical effects of Morita therapy for schizophrenia and schizophrenia-like psychoses.

### Search Strategy

We searched the Cochrane Schizophrenia Groups Trials Register (July 2008), the Chongqing VIP Database (July 2008), the Wanfang Database (July 2008), all references of relevant articles and contacted the first author of each included study.

### Selection Criteria

All relevant randomized control trials (RCTs). Quasirandomized studies, such as those allocating by using alternate days of the week, were included in a sensitivity analysis.

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### Data Collection and Analysis

We reliably selected studies and extracted data independently by 2 researchers (Y.H., C.L.). For homogenous dichotomous data, we calculated random effect, relative risk (RR), 95% confidence intervals (CIs), and, where appropriate, numbers needed to treat (NNT) on an intention-to-treat basis. For continuous data, we calculated weighted mean differences (WMD).

### Main Results

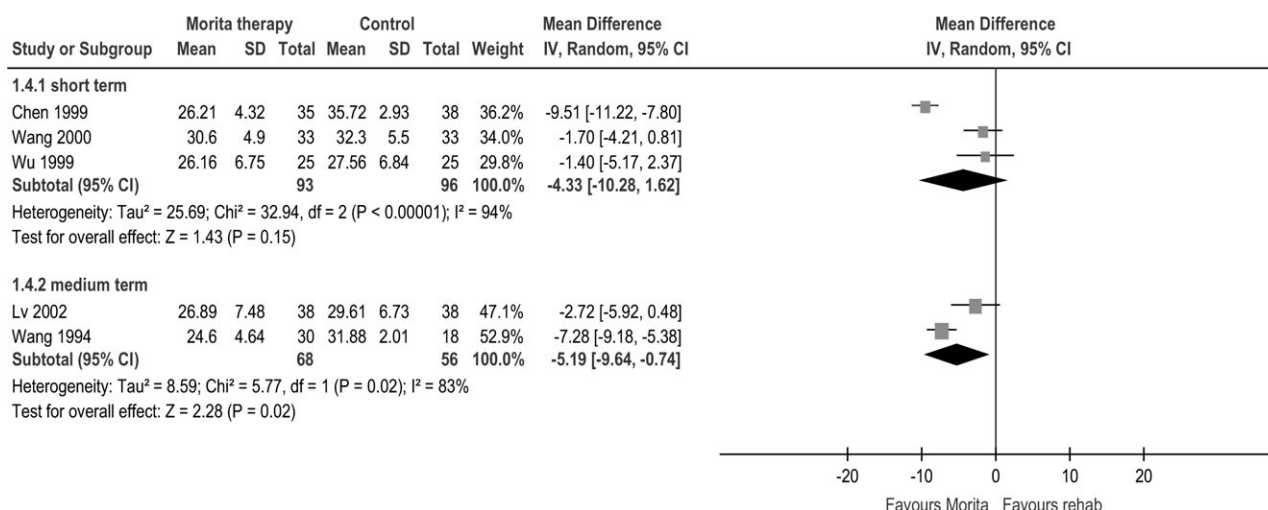
We found 12 small studies of medium-poor quality (total  $n = 1123$ ). Attrition was low in the Morita therapy vs standard care comparison ( $n = 761$ , 10 RCTs,  $<2\%$ ,  $RR = 1.01$ ,  $CI = 0.4$  to  $2.8$ ). Mental status did tend to improve with Morita therapy (Fig. 1,  $n = 76$ , 1 RCT,  $>25\%$ – $30\%$  decline in Brief Psychiatric Rating Scale (BPRS),  $RR = 0.36$ ,  $CI = 0.1$  to  $0.9$ ,  $NNT = 5$ ,  $CI = 4$  to  $25$ ). For negative symptoms Fig. 2, data were inconsistent, with data from 4 trials favoring Morita therapy ( $n = 323$ , Scale for the assessment of negative symptoms endpoint,  $WMD = -12.94$ ,  $CI = -21.6$  to  $-4.3$ ), but heterogeneity was considerable ( $I^2 = 97\%$ ). Morita therapy did significantly improve daily living score compared with standard treatment alone ( $n = 104$ , 1 RCT, ADL endpoint  $WMD = -4.1$ ,  $CI = -7.7$  to  $-0.6$ ). When compared with a rehabilitation program, Morita therapy showed better effect on mental state ( $n = 278$ , 2 RCTs, BPRS endpoint  $WMD = -6.95$ ,  $CI = -9.3$  to  $-4.6$ ,  $I^2 = 0\%$ ) and insight ( $n = 278$ , 2 RCTs, global insight assessment endpoint  $WMD = -1.11$ ,  $CI = -1.3$  to  $-0.9$ ,  $I^2 = 0\%$ ) and social functioning ( $n = 278$ , inpatient psychiatric rehabilitation outcome scale endpoint  $WMD = -18.14$ ,  $CI = -21.3$  to  $-15.0$ ,  $I^2 = 0\%$ ).

### Reviewers' Conclusions

Morita therapy may have some positive effects, but there are no data to assess whether this is sustained. For schizophrenia, therefore, Morita therapy remains an experimental intervention.

### Implications for Practice

The clinical effects of Morita therapy, as far as we were able to demonstrate, are modest, and these are found in



**Fig. 1.** Morita Therapy + Standard Care Vs Standard Care. Mental state: overall average endpoint score (BPRS, high = poor)—short term.

the hands of skilled and committed practitioners. For people with long-term schizophrenia, residual symptoms are often problematic. Morita therapy, although experimental, may have some beneficial effects. It would seem preferential, however, that people with schizophrenia receive such treatment within the context of a well-designed, patient-focused randomized trials. If this is not possible, generating better evidence than we have been able to find here should be a priority for clinicians as well as researchers. Currently we have almost no data to help managers and policy makers balance the costs and benefits of this treatment.

### Implications for Research

We do think that this review supports the need for more studies. Although Morita therapies have mostly been prac-

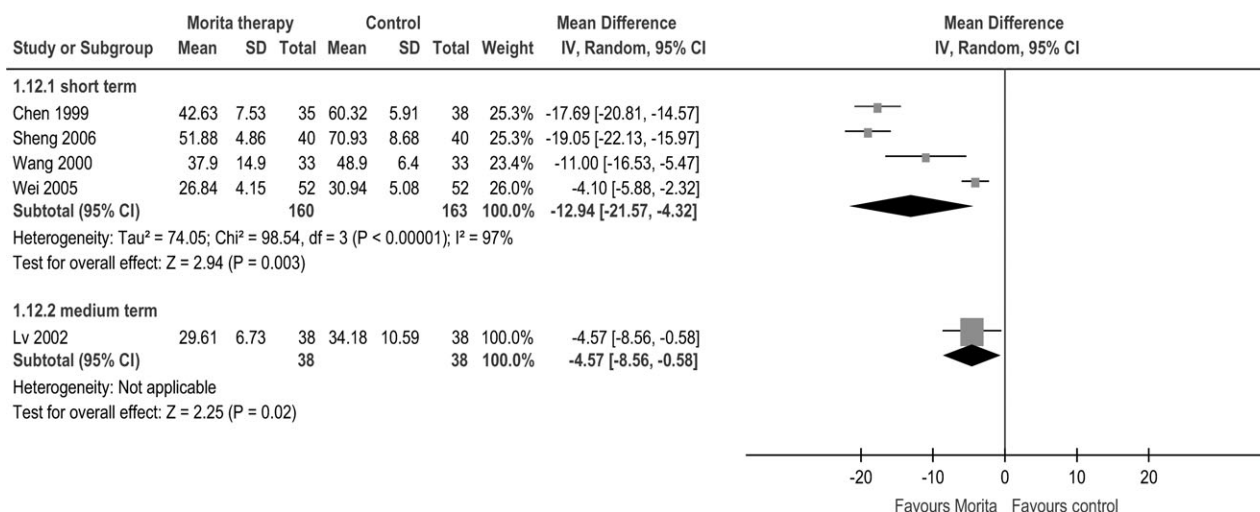
ticed within hospital inpatient settings, we see no reason not to implement this package of care within, eg, day care centers. We would encourage those designing such trials to add patient-focused outcomes such as “healthy days,” “family burden,” “quality of life,” adverse effects as well as some cost effectiveness and cost-benefit evaluations.

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**Fig. 2.** Morita Therapy + Standard Care Vs Standard Care. Mental state: negative symptoms average endpoint score (SANS, high = poor)—short term.

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